bostonsleepcare

SLEEP CLINICAL INTAKE PATIENT QUESTIONNAIRE

85 First Avenue, Waltham, MA 02451 (781) 895-7960 www.bostonsleepcare.com

Appt Date: _____ Date of Birth: _____

Full Name: _____ Age: _____

Occupation: _____ Marital Status: _____

Briefly describe your sleep problem:
List any previous sleep studies:

Current Weight: _____ lbs. Height: _____

Weight 5 years ago was: _____ lbs

What time do you usually go to bed?	am/pm
What time do you usually get up?	am/pm
How long does it take for you to fall asleep generally?	
How many awakenings do you average during the course of a typical night sleep?	
How many hours of sleep do yo average each night?	

Social History:

Do you drink caffeinated beverages? ___ Yes ___ No How much in 24 hours? _____

Do you drink beer or wine? ___ Yes ___ No How much in 24 hours? _____

Do you drink liquor? ___ Yes ___ No How much in 24 hours? _____

Do you smoke any tobacco product? ___ Yes ___ No How much in 24 hours? _____

Past History: (Med / Psych / Surg) (circle all that apply for yourself & family)

Insomnia	Hypertension	ADD/ADHD	Tonsilectomy
Fibromyalgia	Cardiac Arrhythmia	Depression	Palate Surgery
Heartburn or Reflux	Heart Attack	Anxiety	Adenoidectomy
Morning Headaches	Cardiac Surgery	Seizures	Nasal Surgery
Diabetes	Heart Failure	Other _____	Obesity Procedure
Other _____	Stroke		

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Please answer "Yes" or "No" to the following questions:	**Yes**	**No**
1. Do you have periods during the day when you have a desire to nap?	☐	☐
2. Do you have a nap?	☐	☐
3. Do you feel refreshed upon wakening in the morning?	☐	☐
4. Have people told you that you snore or that you stop breathing during the night?	☐	☐
5. Does your snoring disturb others?	☐	☐
6. Do you sleep talk or sleep walk?	☐	☐
7. Do you snack or eat during the night?	☐	☐
8. Do you sleep with either a TV, audio player, or with a light on?	☐	☐
9. Do you have trouble getting to sleep?	☐	☐
10. Do you have trouble staying asleep?	☐	☐
11. Do you feel worried, anxious, or nervous about getting a good night's sleep?	☐	☐
12. Do you experience creeping, crawling, or aching feelings in your legs or the inability to keep your legs still while sitting or while lying in bed?	☐	☐
13. Do you move around in your sleep?	☐	☐
14. Do you dream frequently?	☐	☐
15. Do you hardly ever dream?	☐	☐
16. Have you ever experienced weakness in any part of your body at times of extreme laugher, sadness, or excitement?	☐	☐

17. What position do you prefer to go to sleep in? ___ Back ___ Side ___ Prone

18. What position are you in upon awakening? ___ Back ___ Side ___ Prone

Patient / Responsible Party Signature (state relationship) Date

Office use only:

ROS	congestion	dry mouth
cough	acid reflux	muscle aches
poor memory	leg cramps	nocturia
bruxism	reviewed with patient	

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EPWORTH SLEEPINESS SCALE

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Date: _____

Name: _____ Date of Birth: _____

How likely are you to doze off or fall asleep in the following situations? Even if you have not done some of these things recently try to estimate the effect it might have on your level of drowsiness. Use the following scale to choose the most appropriate number for each situation.

0 = would NEVER **doze**
1 = SLIGHT **chance of dozing**
2 = MODERATE **chance of dozing**
3 = HIGH **chance of dozing**

Situation	**Chance of Dozing**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (in a meeting or watching a movie)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

_____ _____

Patient / Responsible Party Signature (state relationship) Date